

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1909	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/30/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HEALTH AND REHAB CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Complaint investigation #39430 and #39742 were completed at Good Samaritan Health and Rehabilitation Center on 11/30/16. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE